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**2001
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2001)**

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: <u>0041632</u> Facility Name: <u>HERITAGE MANOR EAST-BEARDSTOWN</u> Address: <u>1501 CANAL</u> <u>BEARDSTOWN</u> <u>61701</u> <div style="display: flex; justify-content: space-around; width: 100%;"> Number City Zip Code </div> County: <u>CASS</u> Telephone Number: <u>(217) 323-1900</u> Fax # <u>()</u> IDPA ID Number: <u>370909086016</u> Date of Initial License for Current Owners: <u>05/01/96</u> Type of Ownership: <div style="display: flex; justify-content: space-between;"> <div> <input type="checkbox"/> VOLUNTARY, NON-PROFIT <input type="checkbox"/> Charitable Corp. <input type="checkbox"/> Trust IRS Exemption Code <u> </u> </div> <div> <input checked="" type="checkbox"/> PROPRIETARY <input type="checkbox"/> Individual <input type="checkbox"/> Partnership <input type="checkbox"/> Corporation <input checked="" type="checkbox"/> "Sub-S" Corp. <input type="checkbox"/> Limited Liability Co. <input type="checkbox"/> Trust <input type="checkbox"/> Other <u> </u> </div> <div> <input type="checkbox"/> GOVERNMENTAL <input type="checkbox"/> State <input type="checkbox"/> County <input type="checkbox"/> Other <u> </u> </div> </div>	
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In the event there are further questions about this report, please contact:
Name CRAIG L. ATER **Telephone Number:** (309) 823-7135

DPA 3745 (N-4-99)

IL478-2471

Print Preview

Facility Name & ID Number HERITAGE MANOR EAST-BEARDSTOWN# 0041632 Report Period Beginning: 01/01/01 Ending: 12/31/01

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days,
(must agree with license). Date of change in licensed beds _____

	1	2	3	4	
	Beds at Beginning of Report Period	Licensure Level of Care	Beds at End of Report Period	Licensed Bed Days During Report Period	
1	71	Skilled (SNF)	71	25,915	1
2		Skilled Pediatric (SNF/PED)			2
3	0	Intermediate (ICF)	0	0	3
4		Intermediate/DD			4
5	0	Sheltered Care (SC)	0	0	5
6		ICF/DD 16 or Less			6
7	71	TOTALS	71	25,915	7

B. Census-For the entire report period.

	1	2	3	4	5	
	Level of Care	Patient Days by Level of Care and Primary Source of Payment				
		Public Aid Recipient	Private Pay	Other	Total	
8	SNF	13,303	3,782	823	17,908	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC	0	0	0		12
13	DD 16 OR LESS					13
14	TOTALS	13,303	3,782	823	17,908	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed
bed days on line 7, column 4 69.10%)D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
none

F. Does the facility maintain a daily midnight census? _____

G. Do pages 3 & 4 include expenses for services or
investments not directly related to patient care?
YES ☐ NO ☒H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES ☐ NO ☒I. On what date did you start providing long term care at this location?
Date started 1996J. Was the facility purchased or leased after January 1, 1978?
YES ☒ Date 1996 NO ☐K. Was the facility certified for Medicare during the reporting year?
YES ☒ NO ☐ If YES, enter number
of beds certified _____ and days of care provided 823Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

MODIFIED
ACCRUAL ☐ CASH* ☐ CASH* ☐Is your fiscal year identical to your tax year? YES ☒ NO ☐Tax Year: _____ Fiscal Year: _____
* All facilities other than governmental must report on the accrual basis.

Print Preview

	G/L	RECAP CENSUS	DIFF
PP	3782	3782	0
IPA	13333	13333	0
medicare	823	823	0
	17938	17938	
IPA BEDHOLDS	30		
PP BEDHOLDS	0		
PP CONVERS	0		

STATE OF ILLINOIS

Page 3

Facility Name & ID Number **HERITAGE MANOR EAST-BEARDS** # **0041632** Report Period Beginning: **01/01/01** Ending: **12/31/01****V. COST CENTER EXPENSES** (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY	
		Salary/Wage	Supplies	Other	Total					9	10
	A. General Services	1	2	3	4	5	6	7	8		
1	Dietary	91,716	8,435	0	100,151		100,151	2,195	102,346		1
2	Food Purchase		69,931		69,931		69,931	(360)	69,571		2
3	Housekeeping	47,923	9,312		57,235		57,235	0	57,235		3
4	Laundry	22,226	9,806		32,032		32,032	0	32,032		4
5	Heat and Other Utilities			45,772	45,772		45,772	894	46,666		5
6	Maintenance	22,428	18,327	17,660	58,415		58,415	7,040	65,455		6
7	Other (specify):*							0			7
8	TOTAL General Services	184,293	115,811	63,432	363,536		363,536	9,769	373,305		8
	B. Health Care and Programs										
9	Medical Director			0				0			9
10	Nursing and Medical Records	602,196	22,347	10,033	634,576		634,576	0	634,576		10
10a	Therapy		58,827	16,512	75,339	(179,493)	(104,154)	118,866	14,712		10a
11	Activities	23,587	934	0	24,521		24,521	0	24,521		11
12	Social Services	3,343	0	1,870	5,213		5,213	0	5,213		12
13	Nurse Aide Training	5,641	2,368		8,009		8,009	1,312	9,321		13
14	Program Transportation							0			14
15	Other (specify):*							0			15
16		634,767	84,476	28,415	747,658	(179,493)	568,165	120,178	688,343		16
	C. General Administration										
17	Administrative	45,088			45,088		45,088	19,453	64,541		17
18	Directors Fees							3,046	3,046		18
19	Professional Services			107,591	107,591		107,591	(98,519)	9,072		19
20	Dues, Fees, Subscriptions & Promotions			53,391	53,391	(38,872)	14,519	(2,283)	12,236		20
21	Clerical & General Office Expense	66,191	4,838	14,364	85,393		85,393	105,628	191,021		21
22	Employee Benefits & Payroll Taxes			145,984	145,984		145,984	14,993	160,977		22
23	Inservice Training & Education			259	259		259	575	834		23
24	Travel and Seminar			4,313	4,313		4,313	(2,314)	1,999		24
25	Other Admin. Staff Transportation							0			25
26	Insurance-Prop.Liab.Malpractice			19,654	19,654		19,654	1,079	20,733		26
27	Other (specify):*			12,662	12,662		12,662	(12,662)			27
28	TOTAL General Administration	111,279	4,838	358,218	474,335	(38,872)	435,463	28,996	464,459		28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	930,339	205,125	450,065	1,585,529	(218,365)	1,367,164	158,943	1,526,107		29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Print Preview

Facility Name & ID Number HERITAGE MANOR EAST-BEARDS # 0041632 Report Period Beginning: 01/01/01 Ending: 12/31/01

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass- ification	Reclassified Total	Adjust- ments	Adjusted Total	FOR OHF USE ONLY	
		Salary/Wage	Supplies	Other	Total					9	10
	D. Ownership	1	2	3	4	5	6	7	8		
30	Depreciation			105,617	105,617		105,617	4,732	110,349		30
31	Amortization of Pre-Op. & Org.							0			31
32	Interest			133,003	133,003		133,003	(70)	132,933		32
33	Real Estate Taxes			22,281	22,281		22,281	0	22,281		33
34	Rent-Facility & Grounds			0				5,043	5,043		34
35	Rent-Equipment & Vehicles			4,118	4,118		4,118	9,573	13,691		35
36	Other (specify):*							0			36
37	TOTAL Ownership			265,019	265,019		265,019	19,278	284,297		37
	Ancillary Expense										
	E. Special Cost Centers										
38	Medically Necessary Transportation							0			38
39	Ancillary Service Centers					179,493	179,493	0	179,493		39
40	Barber and Beauty Shops	0	0	28	28		28	0	28		40
41	Coffee and Gift Shops							0			41
42	Provider Participation Fee					38,872	38,872	0	38,872		42
43	Other (specify):*							0			43
44	TOTAL Special Cost Centers			28	28	218,365	218,393		218,393		44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	930,339	205,125	715,112	1,850,576	0	1,850,576	178,221	2,028,797		45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

Print Preview

FOR LINES 1 THRU 28, ENTER ONLY ONE LINE REFERENCE PER ROW. IF SIMILAR ADJUSTMENTS ARE MADE TO MORE THAN ONE LINE, ENTER THE ADDITIONAL ADJUSTMENTS ON LINE 29 OF THIS SCHEDULE AND DETAIL THEM ON PAGE 5A.

STATE OF ILLINOIS

Page 5

Facility Name & ID Number **HERITAGE MANOR EAST-BEARDSTOWN**

0041632

Report Period Beginning: **01/01/01**

Ending: **12/31/01**

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7.

In column 2 below, reference the line on which the particular cost was included. (See instructions.)

		1 Amount	2 Refer- ence	3 OHF USE ONLY	
	NON-ALLOWABLE EXPENSES				
1	Day Care	\$		\$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Program:				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(960)	35		5
6	Rented Facility Space	0	34		6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	0	30		9
10	Interest and Other Investment Income	(9)	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(360)	2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions	0	33		15
16	Personal Expenses (Including Transportation)		24		16
17	Non-Care Related Fees	(884)	20		17
18	Fines and Penalties				18
19	Entertainment	(6,404)	24		19
20	Contributions	(1,192)	27		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(284)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt	(11,470)	27		24
25	Fund Raising, Advertising and Promotional	(4,270)	20		25
	Income Taxes and Illinois Personal				
26	Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees	0	23		27
28	Yellow Page Advertising				28
29	Other-Attach Schedule				29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (25,833)		\$	30

OHF USE ONLY

48		49		50		51		52	
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B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below. (See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	204,054		34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$ 204,054		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B)	\$ 178,221		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference
38	Medically Necessary Transport			\$	38
39					39
40	Gift and Coffee Shops				40
41	Barber and Beauty Shops				41
42	Laboratory and Radiology				42
43	Prescription Drugs				43
44	Exceptional Care Program				44
45	Other-Attach Schedule				45
46	Other-Attach Schedule				46
47	TOTAL (C): (sum of lines 38-46)			\$	47

Print Preview

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET.

IF THESE ARE NOT FOLLOWED, THE FORMULAS WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Summary A

Facility Name & ID Numb HERITAGE MANOR EAST-BEARDSTOWN

0041632 Report Period Beginning:

01/01/01

Ending: 12/31/01

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

Print Summary
A

Operating Expenses		PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
A. General Services														
1	Dietary	0	0	2,195	0	0	0	0	0	0	0	0	2,195	1
2	Food Purchase	(360)	0	0	0	0	0	0	0	0	0	0	(360)	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	894	0	0	0	0	0	0	0	0	894	5
6	Maintenance	0	0	7,040	0	0	0	0	0	0	0	0	7,040	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	(360)	0	10,129	0	0	0	0	0	0	0	0	9,769	8
B. Health Care and Programs														
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	575	0	0	118,291	0	0	0	0	0	0	118,866	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	1,312	0	0	0	0	0	0	0	0	1,312	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Program	0	575	1,312	0	118,291	0	0	0	0	0	0	120,178	16
C. General Administration														
17	Administrative	0	0	19,453	0	0	0	0	0	0	0	0	19,453	17
18	Directors Fees	0	0	3,046	0	0	0	0	0	0	0	0	3,046	18
19	Professional Services	(284)	0	7,470	0	(105,705)	0	0	0	0	0	0	(98,519)	19
20	Fees, Subscriptions & Promotions	(5,154)	0	2,871	0	0	0	0	0	0	0	0	(2,283)	20
21	Clerical & General Office Expenses	0	0	105,628	0	0	0	0	0	0	0	0	105,628	21
22	Employee Benefits & Payroll Taxes	0	0	14,993	0	0	0	0	0	0	0	0	14,993	22
23	Inservice Training & Education	0	0	575	0	0	0	0	0	0	0	0	575	23
24	Travel and Seminar	(6,404)	0	4,090	0	0	0	0	0	0	0	0	(2,314)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	1,079	0	0	0	0	0	0	0	0	1,079	26
27	Other (specify):*	(12,662)	0	0	0	0	0	0	0	0	0	0	(12,662)	27
28	TOTAL General Administration	(24,504)	0	159,205	0	(105,705)	0	0	0	0	0	0	28,996	28
29	TOTAL Operating Expense (sum of lines 8,16 & 28)	(24,864)	575	170,646	0	12,586	0	0	0	0	0	0	158,943	29

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The amounts in the column Q are linked to page 3.

**SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET.
IF THESE ARE NOT FOLLOWED, THE FORMULAS WILL NOT FUNCTION PROPERLY.**

STATE OF ILLINOIS

Facility Name & ID Num**HERITAGE MANOR EAST-BEARDSTOWN** # **0041632** Report Period Beginning: **01/01/01** Ending: **12/31/01** Summary B

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

**Print Summary
B**

	Capital Expense	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	D. Ownership													
30	Depreciation	0	0	0	4,732	0	0	0	0	0	0	0	4,732	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(9)	0	0	(61)	0	0	0	0	0	0	0	(70)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	5,043	0	0	0	0	0	0	0	5,043	34
35	Rent-Equipment & Vehicles	(960)	0	0	10,533	0	0	0	0	0	0	0	9,573	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(969)	0	0	20,247	0	0	0	0	0	0	0	19,278	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Cent	0	0	0	0	0	0	0	0	0	0	0	0	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(25,833)	575	170,646	20,247	12,586	0	0	0	0	0	0	178,221	45

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The amounts in the column Q are linked to page 4.

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Page 6A

Facility Name & ID Number HERITAGE MANOR EAST-BEARDSTOWN # 0041632 Report Period Beginn 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	1 Dietary	\$	Heritage Enterprises, Inc.	100.00%	\$ 2,195	\$ 2,195
16	V	2 Food Purchase				0	
17	V	3 Housekeeping				0	
18	V	4 Laundry				0	
19	V	5 Heat & Other Utilities				894	894
20	V	6 Maintenance				7,040	7,040
21	V	7 Other				0	
22	V	9 Medical Director				0	
23	V	10 Nursing & Medical Records				0	
24	V	11 Activities				0	
25	V	12 Social Service				0	
26	V	13 Nurse Aide Training				1,312	1,312
27	V	14 Program Transportation				0	
28	V	15 Other				0	
29	V	17 Administrative				19,453	19,453
30	V	18 Directors Fees				3,046	3,046
31	V	19 Professional Services				7,470	7,470
32	V	20 Fees, Subscription, Promotion				2,871	2,871
33	V	21 Clerical & General Office Expenses				105,628	105,628
34	V	22 Employee Benefits & Payroll Taxes				14,993	14,993
35	V	23 Inservice Training & Education				575	575
36	V	24 Travel and Seminar				4,090	4,090
37	V	25 Other Admin, Staff Transportation				0	
38	V	26 Insurance-Prop.Liab.Malpract				1,079	1,079
39	Total		\$			\$ 170,646	\$ * 170,646

Sum_6A

2195

894

7040

1312

19453

3046

7470

2871

105628

14993

575

4090

1079

* Total must agree with the amount recorded on line 34 of Schedule VI.

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The adjustments entered on this page will automatically transfer to the summary pages.

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Page 6B

Facility Name & ID Number HERITAGE MANOR EAST-BEARDSTOWN # 0041632 Report Period Beginn 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V 27	Other	\$	Heritage Enterprises, Inc.	100.00%	\$ 0	\$
16	V 30	Depreciation				4,732	4,732
17	V 31	Amortization of Pre-Op & Org				0	
18	V 32	Interest				(61)	(61)
19	V 33	Real Estate Taxes				0	
20	V 34	Rent-Facility & Grounds				5,043	5,043
21	V 35	Rent-Equipment & Vehicles				10,533	10,533
22	V 36	Other				0	
23	V 38	Medically Nec Transportation				0	
24	V 39	Ancillary Service Centers				0	
25	V 40	Barber and Beauty Shops				0	
26	V 41	Coffee and Gift Shops				0	
27	V 42	Other				0	
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$			\$ 20,247	\$ * 20,247

Sum_6B

4732

-61

5043

10533

* Total must agree with the amount recorded on line 34 of Schedule VI.

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The adjustments entered on this page will automatically transfer to the summary pages.

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Page 6C

Facility Name & ID Number HERITAGE MANOR EAST-BEARDSTOWN # 0041632 Report Period Beginn 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V	19 Adjustment for Related Organization	\$ 105,705	Heritage Enterprises, Inc.		\$	\$ (105,705)
16	V						
17	V	10a Adjustment for Related Organization	\$8,545	Green Tree Pharmacy	100.00%	176,836	118,291
18	V						
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$ 164,250			\$ 176,836	\$ * 12,586

Sum_6C

-105705

118291

* Total must agree with the amount recorded on line 34 of Schedule VI.

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The adjustments entered on this page will automatically transfer to the summary pages.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V		\$			\$	\$
16	V						
17	V						
18	V						
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$			\$	\$ *

Sum_6D

* Total must agree with the amount recorded on line 34 of Schedule VI.

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The adjustments entered on this page will automatically transfer to the summary pages.

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Page 6E

Facility Name & ID Number HERITAGE MANOR EAST-BEARDSTOWN # 0041632 Report Period Beginn 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V		\$			\$	\$
16	V						
17	V						
18	V						
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$			\$	\$ *

Sum_6E

* Total must agree with the amount recorded on line 34 of Schedule VI.

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The adjustments entered on this page will automatically transfer to the summary pages.

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Page 6F

Facility Name & ID Number HERITAGE MANOR EAST-BEARDSTOWN # 0041632 Report Period Beginn 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V		\$			\$	\$
16	V						
17	V						
18	V						
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$			\$	\$ *

Sum_6F

* Total must agree with the amount recorded on line 34 of Schedule VI.

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The adjustments entered on this page will automatically transfer to the summary pages.

SEE THE PROCEDURES AT THE BOTTOM OF THE WORKSHEET. IF THESE ARE NOT FOLLOWED, THE FORMULAS ON THE SUMMARY PAGES WILL NOT FUNCTION PROPERLY.

STATE OF ILLINOIS

Page 6G

Facility Name & ID Number HERITAGE MANOR EAST-BEARDSTOWN # 0041632 Report Period Beginn 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V		\$			\$	\$
16	V						
17	V						
18	V						
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$			\$	\$ *

Sum_6G

* Total must agree with the amount recorded on line 34 of Schedule VI.

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The adjustments entered on this page will automatically transfer to the summary pages.

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V		\$			\$	\$
16	V						
17	V						
18	V						
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$			\$	\$ *

Sum_6H

* Total must agree with the amount recorded on line 34 of Schedule VI.

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
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3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
4. For pages 6 thru 6I, related organization costs for therapy must be referenced as line number 10a.
5. The adjustments entered on this page will automatically transfer to the summary pages.

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STATE OF ILLINOIS

Page 6I

Facility Name & ID Number HERITAGE MANOR EAST-BEARDSTOWN # 0041632 Report Period Beginn 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. ☐ YES ☐ NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
Schedule V	Line	Item	Amount	Name of Related Organization	Percent of Ownership	Operating Cost of Related Organization	Adjustments for Related Organization Costs (7 minus 4)
15	V		\$			\$	\$
16	V						
17	V						
18	V						
19	V						
20	V						
21	V						
22	V						
23	V						
24	V						
25	V						
26	V						
27	V						
28	V						
29	V						
30	V						
31	V						
32	V						
33	V						
34	V						
35	V						
36	V						
37	V						
38	V						
39	Total		\$			\$	\$ *

Sum_6I

* Total must agree with the amount recorded on line 34 of Schedule VI.

DO NOT USE DRAG & DROP, CUT OR MOVE COMMANDS. THEY WILL RUIN THE FORMULAS.

1. Enter the information on pages 5 and 5A.
2. For pages 6 thru 6I, the information you enter does not need to be sorted by line reference.
3. For pages 6 thru 6I, a line can be referenced as many times as needed per page.
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5. The adjustments entered on this page will automatically transfer to the summary pages.

Facility Name & ID Number HERITAGE MANOR EAST-BEARDS # 0041632 Report Period Beginning: 01/01/01 Ending: 12/31/01

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8			
						Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**			Schedule V. Line & Column Reference	
							Hours	Percent	Description				Amount
	Name	Title	Function	Ownership Interest									
1	Bill Froelich	Chairman of Board	Management	25.98%	28,846	10	0.20	Directors Fees	\$ 908	line 18, col 7	1		
2	Tom Jefferson	Asst Secretary/Tre	Management	10.15%	28,846	10	0.20	Directors Fees	907	line 18, col 7	2		
3	Craig Hart	Secretary/Treasurer	Management	20.00%	28,846	10	0.20	Directors Fees	907	line 18, col 7	3		
	Joe Warner	President	Management	2.50%	10,302	48	0.95	Directors Fees	324	line 18, col 7			
4	Bill Froelich	Chairman of Board	Management	25.98%	99,509	10	0.20	Salary	3,129	line 17, col 7	4		
5	Tom Jefferson	Asst Secretary/Tre	Management	10.15%	97,892	10	0.20	Salary	3,079	line 17, col 7	5		
6	Craig Hart	Secretary/Treasurer	Management	20.00%	82,710	10	0.20	Salary	2,602	line 17, col 7	6		
7	Joe Warner	President	Management	2.50%	111,368	48	0.95	Salary	3,503	line 17, col 7	7		
8	Bob Dickson	Executive Vice President	Management	0.80%	60,613	50	1.00	Salary	1,907	line 17, col 7	8		
9	Cheryl Lowney	Executive Vice President	Management	0.31%	50,922	50	1.00	Salary	1,602	line 17, col 7	9		
10	Steve Wannemacher	Executive Vice President	Management	0.26%	49,288	50	1.00	Salary	1,551	line 17, col 7	10		
11	Connie Hoselton	Sr Vice President	Management	0.17%	33,864	40	1.00	Salary	1,065	line 17, col 7	11		
12	Craig Ater	Sr Vice President	Management	0.21%	32,235	50	1.00	Salary	1,014	line 17, col 7	12		
13								TOTAL	\$ 22,498		13		

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORT.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

Facility Name & ID Number HERITAGE MANOR EAST-BEARDSTOWN # 0041632 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☒ NO ☐

Name of Related Organization Heritage Enterprises

Street Address 115 W. Jefferson

City / State / Zip Code Bloomington, IL

Phone Number ()

Fax Number ()

B. Show the allocation of costs below. If necessary, please attach worksheets.

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1	1 Dietary	BEDS	2,328	23	\$ 71,961	\$ 71,961	71	\$ 2,195	1
2	2 Food Purchase	BEDS	2,328	23	0	0	71	0	2
3	3 Housekeeping	BEDS	2,328	23	0	0	71	0	3
4	4 Laundry	BEDS	2,328	23	0	0	71	0	4
5	5 Heat & Other Utilities	BEDS	2,328	23	29,301	0	71	894	5
6	6 Maintenance	BEDS	2,328	23	230,824	54,124	71	7,040	6
7	7 Other	BEDS	2,328	23	0	0	71	0	7
8	9 Medical Director	BEDS	2,328	23	0	0	71	0	8
9	10 Nursing & Medical Records	BEDS	2,328	23	0	0	71	0	9
10	11 Activities	BEDS	2,328	23	0	0	71	0	10
11	12 Social Service	BEDS	2,328	23	0	0	71	0	11
12	13 Nurse Aide Training	BEDS	2,328	23	43,025	0	71	1,312	12
13	14 Program Transportation	BEDS	2,328	23	0	0	71	0	13
14	15 Other	BEDS	2,328	23	0	0	71	0	14
15	17 Administrative	BEDS	2,328	23	637,854	637,854	71	19,453	15
16	18 Directors Fees	BEDS	2,328	23	99,885	0	71	3,046	16
17	19 Professional Services	BEDS	2,328	23	244,928	0	71	7,470	17
18	20 Fees, Subscription, Promotion	BEDS	2,328	23	94,145	0	71	2,871	18
19	21 Clerical & General Office Exp	BEDS	2,328	23	3,463,403	3,114,857	71	105,628	19
20	22 Employee Benefits & Payroll	BEDS	2,328	23	491,614	0	71	14,993	20
21	23 Inservice Training & Education	BEDS	2,328	23	18,866	0	71	575	21
22	24 Travel and Seminar	BEDS	2,328	23	134,093	0	71	4,090	22
23	25 Other Admin. Staff Transport	BEDS	2,328	23	0	0	71	0	23
24	26 Insurance-Prop.Liab.Malprac	BEDS	2,328	23	35,366	0	71	1,079	24
25	TOTALS				\$ 5,595,265	\$ 3,878,796		\$ 170,646	25

Print Preview

Facility Name & ID Number HERITAGE MANOR EAST-BEARDSTOWN # 0041632 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e., Days, Direct Cost Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	27	Other	BEDS	2,328	23	\$ 0	\$ 0	71	\$ 0	1
2	30	Depreciation	BEDS	2,328	23	155,150	0	71	4,732	2
3	31	Amortization of Pre-Op & Or	BEDS	2,328	23	0	0	71	0	3
4	32	Interest	BEDS	2,328	23	(1,990)	0	71	(61)	4
5	33	Real Estate Taxes	BEDS	2,328	23	0	0	71	0	5
6	34	Rent-Facility & Grounds	BEDS	2,328	23	165,362	0	71	5,043	6
7	35	Rent-Equipment & Vehicles	BEDS	2,328	23	345,363	0	71	10,533	7
8	36	Other	BEDS	2,328	23	0	0	71	0	8
9	38	Medically Nec Transportation	BEDS	2,328	23	0	0	71	0	9
10	39	Ancillary Service Centers	BEDS	2,328	23	0	0	71	0	10
11	40	Barber and Beauty Shops	BEDS	2,328	23	0	0	71	0	11
12	41	Coffee and Gift Shops	BEDS	2,328	23	0	0	71	0	12
13	42	Other	BEDS	2,328	23	0	0	71	0	13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					\$ 663,885	\$		\$ 20,247	25

Facility Name & ID Number HERITAGE MANOR EAST-BEARDSTOWN # 0041632 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number HERITAGE MANOR EAST-BEARDSTOWN # 0041632 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

B. Show the allocation of costs below. If necessary, please attach worksheets.

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number HERITAGE MANOR EAST-BEARDSTOWN # 0041632 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

Facility Name & ID Number HERITAGE MANOR EAST-BEARDSTOWN # 0041632 Report Period Beginning: 01/01/01 Ending: 12/31/01

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES ☐ NO ☐

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization _____

Street Address _____

City / State / Zip Code _____

Phone Number () _____

Fax Number () _____

1	2	3	4	5	6	7	8	9	
Schedule V Line Reference	Item	Unit of Allocation (i.e., Days, Direct Cost Square Feet)	Total Units	Number of Subunits Being Allocated Among	Total Indirect Cost Being Allocated	Amount of Salary Cost Contained in Column 6	Facility Units	Allocation (col.8/col.4)x col.6	
1					\$	\$		\$	1
2									2
3									3
4									4
5									5
6									6
7									7
8									8
9									9
10									10
11									11
12									12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25	TOTALS				\$	\$		\$	25

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6		7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense		
		YES	NO				Original	Balance					
	A. Directly Facility Related												
	Long-Term												
1	Bank One		XX	Mortgage	\$13,195.00	10/31/99	\$ 1,520,000	\$ 1,342,532	01/31/05	variable	\$ 131,723	1	
2	Bank One Loan Amortization		XX	Mortgage							1,280	2	
3	Central Office Allocation		XX	Interest Income							(61)	3	
4												4	
5												5	
	Working Capital												
6												6	
7											0	7	
8												8	
9	TOTAL Facility Related				\$13,195.00		\$ 1,520,000	\$ 1,342,532			\$ 132,942	9	
	B. Non-Facility Related*												
10	Interest Income										9	10	
11												11	
12												12	
13												13	
14	TOTAL Non-Facility Related						\$	\$			\$ 9	14	
15	TOTALS (line 9+line14)						\$ 1,520,000	\$ 1,342,532			\$ 132,933	15	

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7.
(See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2.
(See instructions.)

Facility Name & ID Number **HERITAGE MANOR EAST-BEARDSTOWN**# **0041632**

Report Period Beginning:

01/01/01

Ending:

12/31/01**IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)****B. Real Estate Taxes**

1. Real Estate Tax accrual used on 2000 report.		Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	\$	20,587	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)			\$	20,910	2
3. Under or (over) accrual (line 2 minus line 1).			\$	323	3
4. Real Estate Tax accrual used for 2001 report. (Detail and explain your calculation of this accrual on the lines below.)			\$	21,958	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)			\$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND \$ For 19 Tax Year. (Attach a copy of the real estate tax appeal board's decision.)			\$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6			\$	22,281	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:	1996		8
	1997		9
	1998		10
	1999		11
	2000		12

FOR OFF USE ONLY	
13	FROM R. E. TAX STATEMENT FOR 2000 \$ 13
14	PLUS APPEAL COST FROM LINE 5 \$ 14
15	LESS REFUND FROM LINE 6 \$ 15
16	AMOUNT TO USE FOR RATE CALCULATIC \$ 16

NOTES:

1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.
This denial must be no more than four years old at the time the cost report is filed.

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IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be

To Print this page only

Hold down
Control Key and hit r

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME HERITAGE MANOR EAST-BEARDSTOWN COUNTY CASS

FACILITY IDPH LICENSE NUMB0041632

CONTACT PERSON REGARDING THIS REPCRAIG L. ATER

TELEPHONE (309)823-7135 FAX # ()

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

(A)	(B)	(C)	(D) Tax Applicable to
<u>Tax Index Number</u>	<u>Property Description</u>	<u>Total Tax</u>	<u>Nursing Home</u>
1. <u>0326400700</u>	<u>HERITAGE MANOR EAST-E</u>	\$ <u>20,911</u>	\$ <u>20,911</u>
2. <u> </u>	<u>HERITAGE MANOR EAST-E</u>	\$ <u>211</u>	\$ <u>211</u>
3. <u> </u>	<u> </u>	\$ <u>526</u>	\$ <u>526</u>
4. <u> </u>	<u> </u>	\$ <u>116</u>	\$ <u> </u>
5. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
6. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
7. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
8. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
9. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
10. <u> </u>	<u> </u>	\$ <u> </u>	\$ <u> </u>
TOTALS		\$ <u>21,764</u>	\$ <u>21,648</u>

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES xx NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 33,800 B. General Construction Type: Exterior Frame Number of Stories

C. Does the Operating Entity? (a) Own the Facility (b) Rent from a Related Organization. (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? (a) Own the Equipment (b) Rent equipment from a Related Organization. (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? YES NO
If so, please complete the following:1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:
3. Current Period Amortization: 4. Dates Incurred:Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1	2	3	4	
	Use	Square Feet	Year Acquired	Cost	
1	Nursing Home		1996	\$ 40,000	1
2	Nursing Home				2
3	TOTALS			\$ 40,000	3

Print Preview

Facility Name & ID Number HERITAGE MANOR EAST-BEARDSTOWN# 0041632 Report Period Beginning: 01/01/01 Ending: 12/31/01**XI. OWNERSHIP COSTS (continued)****B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.**

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	71				\$ 1,744,500	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
9	Improvement Type**										
10	Shower Remodel			1997	9,921						10
11	Heat/Cool Units			1997	2,138						11
12	Roof			1997	101,691						12
13	Interior Rehab			1997	87,411						13
14											14
15	Five Ton Heat Pump			1996	3,257						15
16	Heritage Manor Sign			1996	2,145						16
17	Remodel Physical Therapy Room			1996	18,303						17
18											18
19	Smoke Detectors			1998	5,431						19
20	Back Flow Preventers			1998	3,155						20
21	Interior Rehab			1998	144,749						21
22											22
23	Water Heater			1999	3,991						23
24	Alzheimer Unit--material			1999	51,576						24
25	Alzheimer Unit--Labor			1999	14,502						25
26	Alzheimer Unit--Professional Fees			1999	21,605						26
27	Interior Rehab			1999	30,944						27
28											28
29	Alzheimer Unit--material			2000	27,447						29
30	Alzheimer Unit--Labor			2000	5,812						30
31	Alzheimer Unit--Professional Fees			2000	1,310						31
32	Fire Alarm Panel			2001	2,026						32
33	Electric Door			2001	2,378						33
34	C/O Allocation							4,732	4,732		34
35	Book Depreciation					74,618		74,618		372,190	35
36					2,284,292						36

* Total beds on this schedule must agree with page 2.

See page 12A, Line 70 for total

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Preview

0 Page 12B
0 Page 12C
0 Page 12D
0 Page 12E
0 Page 12F
0 Page 12G
0 Page 12H
0 Page 12I

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
37								37
38								38
39								39
40								40
41								41
42								42
43								43
44								44
45								45
46								46
47								47
48								48
49								49
50								50
51								51
52								52
53								53
54								54
55								55
56								56
57								57
58								58
59								59
60								60
61								61
62								62
63								63
64								64
65								65
66								66
67								67
68								68
69								69
70 TOTAL (lines 4 thru 69)		\$ 0	\$ 74,618		\$ 79,350	\$ 4,732	\$ 372,190	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Preview

Facility Name & ID Numbe HERITAGE MANOR EAST-BEARDSTOWN

0041632

Report Period Beginning:

01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1 Totals from Page 12A, Carried Forward		\$ 0	\$ 0		\$ 0	\$	\$ 372,190	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34 TOTAL (lines 1 thru 33)		\$ 0	\$ 0		\$ 0	\$ 0	\$ 372,190	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Preview

Facility Name & ID Numbe HERITAGE MANOR EAST-BEARDSTOWN

0041632

Report Period Beginning:

01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1 Totals from Page 12B, Carried Forward		\$ 0	\$ 0		\$ 0	\$	\$ 372,190	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34 TOTAL (lines 1 thru 33)		\$ 0	\$ 0		\$ 0	\$ 0	\$ 372,190	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Print Preview

Facility Name & ID Numbe HERITAGE MANOR EAST-BEARDSTOWN

0041632

Report Period Beginning:

01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1 Totals from Page 12C, Carried Forward		\$ 0	\$ 0		\$ 0	\$	\$ 372,190	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34 TOTAL (lines 1 thru 33)		\$ 0	\$ 0		\$ 0	\$ 0	\$ 372,190	34

**Improvement type must be detailed in order for the cost report to be considered complete.

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B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

Hold down
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1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1 Totals from Page 12D, Carried Forward		\$ 0	\$ 0		\$ 0	\$	\$ 372,190	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34 TOTAL (lines 1 thru 33)		\$ 0	\$ 0		\$ 0	\$ 0	\$ 372,190	34

**Improvement type must be detailed in order for the cost report to be considered complete.

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

Hold down
Control Key and hit w

1	3	4	5	6	7	8	9	
Improvement Type**	Year Constructed	Cost	Current Book Depreciation	Life in Years	Straight Line Depreciation	Adjustments	Accumulated Depreciation	
1 Totals from Page 12E, Carried Forward		\$ 0	\$ 0		\$ 0	\$	\$ 372,190	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18
19								19
20								20
21								21
22								22
23								23
24								24
25								25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34 TOTAL (lines 1 thru 33)		\$ 0	\$ 0		\$ 0	\$ 0	\$ 372,190	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number HERITAGE MANOR EAST-BEARDSTOWN # 0041632 Report Period Beginning: 01/01/01 Ending: 12/31/01

XI. OWNERSHIP COSTS (continued)**C. Equipment Depreciation-Excluding Transportation. (See instructions.)**

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Componer Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	\$ 211,348	\$ 30,999	\$ 30,999	\$		\$ 152,008	71
72	Current Year Purchases	7,740						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 219,088	\$ 30,999	\$ 30,999	\$		\$ 152,008	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

	1	2	
	Reference	Amount	
81	Total Historical Cost (line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$ 2,543,380	81
82	Current Book Depreciation (line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$ 105,617	82
83	Straight Line Depreciation (line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$ 110,349	83
84	Adjustments (line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$ 4,732	84
85	Accumulated Depreciation (line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$ 524,198	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		\$	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

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XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: _____

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? _____

If NO, see instructions.

☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				\$ 0			3
4	Additions							4
5								5
6								6
7	TOTAL				\$			7

8. List separately any amortization of lease expense included on page 4, line 34. _____

This amount was calculated by dividing the total amount to be amortized _____
by the length of the lease _____.

9. Option to Buy: ☐ YES ☒ NO Terms: _____ *

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipm: \$ **13,691** Description: **Copier, Cell Phone and Central Office Allocation**

(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			\$	\$	17
18					18
19					19
20					20
21	TOTAL		\$	\$	21

10. Effective dates of current rental agreement:

Beginning _____

Ending _____

11. Rent to be paid in future years under the current rental agreement:

Fiscal Year Ending Annual Rent

12. **/2001** \$ _____

13. **/2002** \$ _____

14. **/2003** \$ _____

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Print Preview

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Facility Name & ID Number HERITAGE MANOR EAST-BEARDSTOWN # 0041632 Report Period Beginning: 01/01/01 Ending: 12/31/01

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

<p>1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?</p> <p><input type="checkbox"/> YES <input type="checkbox"/> NO</p> <p>If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.</p>	<p>2. CLASSROOM PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>COMMUNITY COLLEGE <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>	<p>3. CLINICAL PORTION:</p> <p>IN-HOUSE PROGRAM <input type="checkbox"/></p> <p>IN OTHER FACILITY <input type="checkbox"/></p> <p>HOURS PER AIDE _____</p>
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B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	\$	\$	\$	\$
2	Books and Supplies		2,368		2,368
3	Classroom Wages (a)		5,641		5,641
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)		0		
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	\$	\$ 8,009	\$	\$ 8,009
10	SUM OF line 9, col. 1 and 2 (e)	\$ 8,009			

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
 (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
 (c) For in-house training programs only. Do not include fringe benefits.
 (d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities

\$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

- (e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
 (f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

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Facility Name & ID Number HERITAGE MANOR EAST-BEARDSTOWN# 0041632

Report Period Beginning:

01/01/01

Ending:

12/31/01

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

		1	2	3	4	5	6	7	8	
	Service	Schedule V	Staff		Outside Practitioner		Supplies (Actual or Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
		Line & Column Reference	Units of Service	Cost	(other than consultant)					
					Units	Cost				
1	Licensed Occupational Therapist	10a/3	hrs	\$		\$ 3,745	\$		\$ 3,745	1
2	Licensed Speech and Language Development Therapist	10a/3	hrs			3,728			3,728	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a/3	hrs			6,958	282		7,240	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39/3	# of prescripts				176,837		176,837	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):	39/3				2,656			2,656	13
14	TOTAL			\$		\$ 17,087	\$ 177,119		\$ 194,206	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

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drugs 118292

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	\$ 1,670	\$	1
2	Cash-Patient Deposits	11,799		2
3	Accounts & Short-Term Notes Receivable- Patients (less allowance)	253,844		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	13,515		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	(1,636,499)		8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	\$ (1,355,671)	\$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	40,000		13
14	Buildings, at Historical Cost	2,284,292		14
15	Leasehold Improvements, at Historical Cos			15
16	Equipment, at Historical Cost	219,088		16
17	Accumulated Depreciation (book methods)	(524,198)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):	454		23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	\$ 2,019,636	\$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	\$ 663,965	\$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	\$ 29,509	\$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	11,799		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	71,622		30
31	Accrued Taxes Payable (excluding real estate taxes)	4,363		31
32	Accrued Real Estate Taxes(Sch.IX-B)	21,958		32
33	Accrued Interest Payable	356		33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36		0		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	\$ 139,607	\$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	1,342,532		40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	\$ 1,342,532	\$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	\$ 1,482,139	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$ (818,174)	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$ 663,965	\$	48

*(See instructions.)

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XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	\$ (687,401)	1
2	Restatements (describe):		2
3	audit Adjustment	0	3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	\$ (687,401)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(130,773)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	()	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	\$ (130,773)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	\$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	\$ (818,174)	24 *

* This must agree with page 17, line 47.

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STATE OF ILLINOIS

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Facility Name & ID Number HERITAGE MANOR EAST-BEARDSTOW # 0041632 Report Period Beginning: 01/01/01 Ending: 12/31/01

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

1			
Revenue		Amount	
A. Inpatient Care			
1	Gross Revenue -- All Levels of Care	\$ 1,743,041	1
2	Discounts and Allowances for all Levels	(161,003)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 1,582,038	3
B. Ancillary Revenue			
4	Day Care	0	4
5	Other Care for Outpatients		5
6	Therapy	29,246	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 29,246	8
C. Other Operating Revenue			
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements	3,112	11
12	Gift and Coffee Shop	580	12
13	Barber and Beauty Care	380	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	0	16
17	Sale of Drugs	103,591	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	847	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 108,510	23
D. Non-Operating Revenue			
24	Contributions	0	24
25	Interest and Other Investment Income***	9	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 9	26
E. Other Revenue (specify):****			
27	Settlement Income (Insurance, Legal, Etc.)		27
28		0	28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 1,719,803	30

2			
Expenses		Amount	
A. Operating Expenses			
31	General Services	\$ 363,536	31
32	Health Care	747,658	32
33	General Administration	474,335	33
B. Capital Expense			
34	Ownership	265,019	34
C. Ancillary Expense			
35	Special Cost Centers	28	35
36	Provider Participation Fee		36
D. Other Expenses (specify):			
37	<u>Non Nursing Home Revenue/Expense</u>	0	37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 1,850,576	40
41	Income before Income Taxes (line 30 minus line 40)**	(130,773)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (130,773)	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

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